MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, October 10, 2002
10:18 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
SHEILA P. BURKE
AUTRY O.V. "PETE" DeBUSK
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: County-level variation in Medicare per capita spending -- Dan Zabinski, Scott Harrison

DR. ZABINSKI: As the title suggests, this is primarily a presentation on the variation in per capita spending and local Medicare spending, but this analysis of the variation is actually part of a larger study we intend to do on improving the payment system in Medicare+Choice. So before we specifically get into the variation analysis, I will briefly review our workplan on that larger study.

The starting point for this larger study is the Commission's recommendation in the March 2001 report that payments in the Medicare+Choice and the fee-for-service Medicare programs should be financially neutral within local markets. This runs counter to the Balanced Budget Act of 1997, which reduced the link between M+C payments and fee-for-service spending in order to reduce the geographic differences in M+C payments.

The Commission, however, said that the geographic differences in M+C payments should be addressed through the variation in local fee-for-service spending and recommended that the Secretary analyze that variation.

In addition, the Commission recognized that Medicare's current policy of using counties as the payment area can result in unreliable estimates of local fee-for-service spending. In response, the Commission also recommended that the Secretary consider the definition of local payment areas and explore alternative payment areas that have enough beneficiaries to produce reliable estimates of spending.

More recently, the Commission has expressed interest in having MedPAC's staff investigate the issues of variation in per capita local spending and payment areas in Medicare+Choice, and we intend to include analysis of those issues in a chapter for the March report.

Also, the financial neutrality between the Medicare+Choice and fee-for-service sectors requires an effective risk-adjustment system. CMS has proposed a system that is intended for use beginning in 2004, and we plan to include an assessment of that system in our study for the March report.

Now, to get the ball rolling on this larger study, we started by analyzing the variation in per capita local fee-for-service spending, and that work is the focus of the rest of this presentation.

We started by looking at factors that affect variation in fee-for-service spending, and the first of these is input prices. MedPAC work has shown a strong geographic relationship between the way that we measure input prices and the wages in other occupations. Also, geographic differences in the way we measure input prices are strongly associated with geographic differences in the cost of living.

Other factors that affect variation in per capita spending

include IME, GME and DSH payments, beneficiaries' health status, beneficiaries' service use, which can include the effects of providers' practice patterns and beneficiaries' propensity to consume care, and the final factor that affects variation that we identified is differences in use in Medicare covered services provided in VA and DoD facilities.

Now we wanted to estimate the variation in per capita spending that is attributable to each of those factors. Our database for obtaining those estimates is a spreadsheet of county data on fee-for-service Medicare spending, input prices, health status and IME, GME and DSH payments. This database allows us to obtain reliable estimates of the variation in per capita county spending that is attributable to input prices and IME, GME and DSH payments, but we also have a couple of issues that I think I should point out regarding the database.

The first issue is that our measure health status is county risk scores from the principal inpatient diagnostic cost group or PIP-DCG risk-adjustment system that CMS currently uses in Medicare+Choice. Now we realize that there is no health status measure that fully accounts for the differences between beneficiaries, but there are measures that actually do a better job than a PIP-DCG, such as the hierarchical condition category or HCC risk adjustment system.

But we chose to use the PIP-DCG, rather than something like the HCC, because we have PIP-DCG risk scores for the entire fee-for-service Medicare population, but the HCC risk scores that we have are based on a 5-percent random sample, and we estimate that that 5-percent sample is probably too small to give us reliable estimates in about 25 percent of the counties.

A second issue regarding the database is IME, GME, and DSH spending cannot directly estimate the variation attributable to differences in service use and to differences in use of VA and DoD facilities because we don't have data on those variables.

Now these next two slides display the results of our analysis. On this first diagram, we show the distribution of per capita county spending before and after we remove factors that affect variation. Along the horizontal axis of this diagram, we show the levels of county per capita spending. The green bars on the diagram show the percentage of counties that have per capita spending at each level. The black bars indicate the percentage of counties at each level, after we adjust for differences in input prices, health status, and IME, GME and DSH spending.

What the diagram reveals is that removing these factors from per capita spending reduces the number of counties that are towards the tail of the distribution and increases the number of counties around the central tendency. An important note, though, is that we weighted the distribution by the number of beneficiaries in each county. What that means, for example, is that a county with 10,000 beneficiaries will count twice as much in the distribution as a county with 5,000 or half as many beneficiaries.

Now, in this second diagram, we show the relative importance of the factors that affect variation in per capita spending.

Specifically, what we did is we first calculated a beneficiary-weighted variance in per capita county spending without any adjustments. Then we first of all removed the effects of differences in input prices and calculated the percentage change in the variance. Then we did essentially the same thing with health status and DSH, IME and GME payments.

We found that removing input prices has, by far, the largest effect on reducing the variance, decreasing it by 33 percent. Removing health status has the second-largest effect, followed by DSH, IME and GME payments. Now, due to data limitations, we cannot estimate the effects of removing service use differences or use of VA and DoD care, but we do conjecture that serious use has a larger effect on the variation than does use of VA and DoD facilities.

Finally, I would also like to point out that when we simultaneously removed the effects of input prices, health status and IME, GME and DSH payments, the variance declines by about 62 percent.

Now, in closing, I'd like to say that we really view this variation analysis as a starting point, and as we turn things over to the Commission, we are looking for your thoughts on the direction you would like us to take this analysis. One possibility that I see is that we could take a relatively broad perspective and consider appropriate policies for addressing variation in local fee-for-service spending, which would in turn have an indirect effect of addressing variation in M+C payments and would be consistent with the Commission's view that differences in M+C payments should be addressed through variation in fee-for-service spending.

But I think another possibility is to take a little bit more narrow perspective and consider which of the factors that affect variation in fee-for-service spending should be reflected in M+C payments. For example, a fair amount of the variation is, in fee-for-service spending, is within the direct control of policy levers, and we can consider whether any of these policies should be modified so that the appropriate costs are then reflected in the M+C payments.

MR. HACKBARTH: Dan, the latter approach would be a departure, wouldn't it, from what we've had as our guiding principle in M+C, which is we ought to be offering beneficiaries a choice: pay, as best we can, the same amount to private plans as we would pay on their behalf if they stayed in Medicare, and we have laid out a bunch of reasons why a gap between what we pay private plans and what we pay under traditional fee-for-service causes problems.

So I'm not clear why we would want to consider the second option.

DR. ZABINSKI: I guess I picture it as, we have considered things like, for example, ProPAC, in the past, considered the appropriateness of including DSH payments in M+C or, at that time, risk-plan payments, and due to the nature of what DSH payments are for, you know, supporting hospitals that provide a lot of indigent care, you know, perhaps a more appropriate policy might be or at least they recommended excluding DSH payments from

the risk plan base rates, and then paid the hospitals directly for each risk plan enrollee that goes to the indigent care hospital, something like that. I don't know, it's something that the Commission might want to consider.

DR. MILLER: You also recall, I tried to talk about this a little bit up front. I think there's, among the staff, and we're looking at the question that you've asked, and we're not precisely clear what direction it came in. it sort of came out of an M+C conversation to look at geographic variation in fee-for-service.

One could look at it purely on that side and ask about policy implications there. That would be one approach, which is what I think Dan is saying, or, alternatively, on the M+C side, and we're looking for a little direction, given this request, what you had in mind for this. I think that's part of what we're trying to pose here.

MS. BURKE: Going to the example that Dan used, the other obvious one that has been the subject of a fair amount of discussion for some years has been the treatment of GME and IME for very similar reasons, which is to what extent it should be in a base rate and to what extent it should, in fact, be a direct payment to an institution for a specific activity.

I think there is, in fact, and there should well be, a conversation about that as the structure of the base rates because it is a fundamental question as to whether or not we should replicate solely on the basis of one-to-one or should it, in fact, reflect what it is we expect we are paying for. And so that, to me, would seem to be a series of issues that ought to, in fact, be engaged, as we look at it, but it is a question really on the fee-for-service base, which is what ought to be in the base as an expectation, and then should we duplicate that as some percentage in calculating M+C.

So I think Dan's example is exactly right, and I think it could be expanded to do the other things that are policy choices that are part of the payment rate that are distinct. I mean, the input prices are what they are, and they are reflected across the board, but the other issues, those remaining three, DSH, IME and GME, are obvious policy presumptions in the way we have calculated the rates and may well want to be revisited, whether you use that in a base or not.

Health status, similarly, I think like input, is what it is. Can we do a good job of it? But I think the other three warrant some question in calculating M+C.

DR. WAKEFIELD: Three sort of unrelated topics. From the text that you provided us with prior to the meeting, I appreciated the comment about beneficiary populations in small counties and the difficulty of estimating per capita spending. Those erratic changes from year-to-year I think are absolutely worth noting, and I appreciated seeing that point reflected in the text.

Now two questions. One, you also said in text for 2004 that CMS has a system that is combining both demographic data and in-patient data, but you didn't mention outpatient, and I thought outpatient was also a category that was going to be factored in.

Am I wrong about that?

DR. ZABINSKI: Not at all. I'll have to look at what I wrote there, but if I said that, that was completely off-base. It is a broader context of inpatient, outpatient and physician office visits.

DR. WAKEFIELD: Okay. Then the third point that I wanted to ask about, I understand the difficulty of being able to quantify the DoD and VA impact, that, whatever those differences are, they would really resonate at the county level, right? So, for example, Montgomery County, probably a big impact for DoD and another county perhaps not much impact at all.

So, when you are commenting on beneficiary use of VA and DoD facilities driving down per capita spending in traditional Medicare, it is really at the county level that you are talking primarily, not so much in the aggregate nationally, although you have impact there, too. If I am wrong about that, please let me know.

The second point I was kind of wondering, along that same line, is there any interplay between, again, it would be in very sort of localized ways, but is there any interplay between IHS and Medicare II or is that just completely separate, different from the DoD/VA populations? If you think about Nevada, or Arizona, or Oklahoma, for example, would there be some county impact there, as you would see with DoD or is that just completely separate?

DR. ZABINSKI: I don't know about the IHS. Maybe somebody else does. But I think you are right about the county-level variation in the VA/DoD. I mean, even from a 1996 ProPAC report, there is even a fair amount of state variation, not huge, but some, at the VA/DoD measure. So I would think the variation is even greater at the county level.

MS. ROSENBLATT: Dan, I thought this was a great analysis, but it raised quite a few questions in my mind on the calculations.

This chart showing the effect of variation, this is the variation in per capita fee-for-service spending?

DR. ZABINSKI: Right. Yes.

MS. ROSENBLATT: So a couple of months ago the commissioners were shown an exhibit where the issue was that we had the numerator and denominator reflected the fact that we had snowbirds, so that there were services performed in another county, and wouldn't that be one of the factors we need to account for here, particularly if we're going to use these conclusions for the M+C program, where everyone would have their services in the service are of the M+C program?

DR. ZABINSKI: If I follow your thinking, and I think I do, I believe the data account for that. In this database, say you have a beneficiary who lives in County A, but they go get care in County B, that care that they got in County B actually gets included in the per capita rate for County A.

MS. ROSENBLATT: But then it's distorting the price, if you will, of County A. So if there is any way to segment that --

DR. ZABINSKI: I have thought about that, Alice, and so far I haven't come up with anything. I don't want to like stab it in

the heart right now, but I am not hopeful for finding a good way. But there's two things: I mean, I'd really like to get VA/DoD data and this particular point you're raising.

MS. ROSENBLATT: Then I have another question. When you're pulling out health status, is that based on the PIP-DCG for M+C or is that based on the PIP-DCG for the whole fee-for-service population?

DR. ZABINSKI: It's for the fee-for-service population.

MS. ROSENBLATT: It is?

DR. ZABINSKI: Yes.

MS. ROSENBLATT: My last question is, when you talked about being unable to look at service use, I read the statement that you couldn't differentiate between practice patterns versus propensity to seek care. If we were to say that's real hard, forget about that, but can we at least look at the impact of service use by county in total, whatever the cause of the service use difference, can we do that?

DR. ZABINSKI: Ultimately, if I can get VA/DoD amounts then you would think that then I would have measures on all of the factors that affect variation then except service use, and so any remainder I think would then be service use. I think that is right. I'm not 100-percent certain, but I think that is the right way to look at it.

MS. ROSENBLATT: I'm uncomfortable with anything that uses a remainder approach. So if there is any way of looking directly at service use from whatever cause, then I would be real interested in looking at that.

DR. ZABINSKI: Okay.

DR. NEWHOUSE: I have a narrow technical comment and then a broader comment. The technical comment is, I think you threw out the HCC measure prematurely. I mean, granted that you can't use it for 25 percent of the counties, you could still use 75 percent of the counties to get an estimate of how much the variation is reduced.

DR. ZABINSKI: That's something we're definitely considering.

DR. REISCHAUER: It is 75 percent of the counties and probably 95 percent of the population.

DR. ZABINSKI: You're probably right about that.

DR. NEWHOUSE: I'd much rather see your health status number based on 75 percent of the counties for the PIP-HCC than what you have got up there.

DR. ZABINSKI: I did run the numbers with the HCC.

DR. NEWHOUSE: What happened?

DR. ZABINSKI: You got a lot more variation accounted for by the health status.

DR. NEWHOUSE: Right.

DR. ZABINSKI: Maybe even, and I don't remember exactly, but maybe 50-percent more than what we are showing here.

DR. NEWHOUSE: Was that on 100 percent of the counties or 75 percent of the counties?

DR. ZABINSKI: That was on 100 percent of the counties.

DR. NEWHOUSE: Well, why don't you run it on 75 percent of

the counties and see what you get.

DR. ZABINSKI: I agree with that.

MR. SMITH: Joe, can I just say for a second -- that data, I assume that the 17 increases, but the residual decreases. It doesn't come from input prices or --

DR. ZABINSKI: Right.

DR. NEWHOUSE: I want to go to the issue of what the context is for this endeavor. One context, which is a narrow context and which I think I come out at for the moment is just essentially an educational mission on what accounts for the variation, where the bottom line is kind of don't get too carried away with the raw variation because we can, in fact, account for it. Sheila's point on the policy measures I agree with. That is one context.

The broader question it seems to me that this raises, but I don't know what to do with it, is what should the policy be toward variation in traditional Medicare? And it seems to me that if you start approaching that question, the only thing I can think about is kind of spending caps or floors maybe, and I can't imagine caps working, I mean, particularly at the county level or even at the state level, for that matter.

I am comfortable in just not going there and leaving this in the context of the variation is kind of not as great as it seems. There is also, by the way, particularly at the county level, in effect, according to what Mary said in a different context, I mean, there is some variation that at the annual level is just random. I mean, it kind of dies down when you weight the variation, but the unweighted variation at the county or even at the state level, there will be some noise just from random events in a year.

DR. ZABINSKI: Joe, do you think it would be helpful, thinking of that the variation from year-to-year, to use two years' of data together?

DR. NEWHOUSE: Yes.

DR. ZABINSKI: Because we do have that, and I actually looked at it, and it reduces the overall variation, by my recollection, by about 15 percent.

DR. NEWHOUSE: Yes, and maybe more. I mean, maybe more years, rather.

DR. ZABINSKI: I've only got two years, so I think that we're stuck at --

DR. NEWHOUSE: Well, one thing you could do is you could show how much reduction it makes going from one to two, and you could potentially get an estimate from that of what it would do to go to more years.

MR. DURENBERGER: I think the questions I was going to raise have been touched on, to some degree, by this series of questions and responses. As long as I have known Joe, I have heard him say variation is not as great as it seems. That always sort of like gets my hackles up, and I don't know why because I don't have his talent, but I cannot accept -- just experience does not allow me to accept that.

I mean, I can't go back, for example, to Billings or Grand Forks or Minneapolis-St. Paul and say that something like over a third or a third of this is input price variation just for

starters. You say that it is, but it's kind of like hard to do. It's one of the reasons why congressmen and governors in Iowa get all upset during elections and talk about what are you doing.

But that leads me to the second point --

MR. HACKBARTH: Could I just ask for a clarification, Dave? Are you saying that it doesn't right to you? You don't believe that one-third is input prices or you think the input price adjustments are inaccurate?

MR. DURENBERGER: No, the large percentage of the variation that is attributable to input prices -- it's, what, 34 or 35 percent, something like that?

MR. MULLER: The factors vary two to one.

MR. DURENBERGER: Pardon?

MR. MULLER: The wage factors vary two to one so that is quite possible.

MR. DURENBERGER: I'm just telling you, from a political standpoint, a lot of people don't believe that. There is a big debate over the wage index going on now and a lot of things like that, and I'm not, please, on this one, I'm not arguing. It's the second one, the next one that I would like to go to, which is the provider practice patterns and the issues of the beneficiary propensity to use care.

I think I have already suggested either Wennberg or Skinner or somebody call you and talk to you about --

DR. ZABINSKI: Skinner called me already. I have known John for 15 years.

MR. DURENBERGER: I thought you had. Yes, I was hoping he had, because these kinds of issues in variation in practice across the country, and even within our own states, and communities and so forth, are hard to come to grips with. I mean, it's hard to come to grips with them in statistical terms. And those of us who would argue on behalf of the Marshfield Clinic or whoever it may be are sometimes hard-pressed to lay a solid foundation under that, premised on the kind of work that is done by some of our colleagues here and by Jack Wennberg and others.

I just hope that we find a way over time to go into that issue and to talk about it in ways that folks on the hill can begin to understand, and doctors, and hospitals back home can understand.

And then the last one, of course, the one that goes with propensity on behalf of beneficiaries and practice patterns, is the issue of effectiveness, and I know that's really hard to get into, but I just want to lay it on the table because I think it's important for us, at some point, to get into it. Particularly, if we started in the context of Medicare+Choice, the issue is under Medicare+Choice, we're going to reward beneficiaries with more benefits, and we're going to reward doctors and hospitals with more money. It's legitimate to ask the question, for what? What is the value? What is the benefit in 500,000 knee surgeries that prove, in effect, or whatever, you know, I don't want to get into all of the details of this, but that particular issue of what are we buying with this, again, becomes important to those of us who have gone through the experiences, at least in

our part of the country, say, 25/20 years ago with the first-ever risk contracts and so forth and seeing behavior change and then not get rewarded.

The issue is how do you explain to people where the incentives are to improve and enhance the practice of medicine and then get rewarded financially or penalized financially for doing that.

MR. HACKBARTH: The variation, based on differences in practice patterns and propensity to use services, is large and well-documented. We can add our voice to the chorus of people that have called attention to that. I think the question that it begs is, okay, what could, what should Medicare do about it? And I think that is the difficult part. It would involve a Medicare program with a whole different premise than the original Medicare program, which quite explicitly was we're not going to shape medical practice, we're going to pay bills.

Here, the Federal Government would be saying this is the appropriate standard of medical practice, and we are going to force people towards the explicit federal standard. I think that is the debate that you would have to have.

MR. DURENBERGER: May I respond? I'm glad you laid it out that way because I didn't come on this Commission to stay with the old system, to get very blunt about it.

So the answer to your question, and I think Joe raised the same issue, comes tomorrow sometime when we start listening to some of the folks talk about quality, but expressed in, say, CMS terms, it is pay for performance, and it is a drastic, it is clearly a drastic change. But if it doesn't come from us, from whom is it going to come? I guess that is the bottom line of the question.

MR. MULLER: I think that discussion indicates why it is important to continue the very fine work you have done here to try to explain the variance. I think all of us have read the Wennberg literature over the years, and to get 62 percent I think is a good step forward in terms of understanding the variation. I think Joe's suggestion -- I don't know what his estimate is as to by looking at health status through those codes might drive that number up more. So I think, in part, if the residual -- as I said 62 -- if the residual is 20 percent, and as Al said one can contribute all kinds of things to residuals, that is a different debate than if the residual is 80 percent.

I think sometimes we discuss the variation around the country as if it wasn't due to GME, IME, DSH, health status and input prices. So, in fact, I think one of the ways we can help this debate quite a bit is to drive this number as close to 100 as we can, understanding that these are policy variables that are in this chart right here that -- some of these are policy variables -- that are reasonably well established.

Some of them obviously, like input prices, reflect realities -- one may like them or not like them, but they reflect significant realities around the country. So to continue this work to try to clarify as much of the variations as we can explain by these variables, I think it may perhaps help this debate quite a bit because I think there is a tendency, an

increased tendency to think about the variation in the country as just due to practice style, and I think we can help clarify exactly how much that is practice style and how much that, in fact, is due to the factors here.

So I would urge us to get this number up as high as we can get it, in terms of legitimate explanation.

MR. SMITH: Dan, I found this very helpful, and for reasons that Ralph just expressed, it seems to me this is stuff we ought to press ahead.

One observation and one question. I found the compression around the central tendency equally powerful as the 62 percent. There is less here than sometimes the political discussion, which we need to be mindful of, but there is less unexplained difference across a smaller range going on than the political discourse sometimes suggests, and I think we ought to bear that in mind, as well as 62 percent is explaining a lot.

My question is I found myself wondering several times as I read this, whether or not there is a useful connection to explore between input prices and propensity to seek care or practice patterns. Last year, when we spent a lot of time looking at rural issues, we looked at a fair amount of data which suggested that the relative lack of availability of Medigap and relatively lower incomes depressed the choice to utilize services by rural residents.

I am wondering whether or not there is a cost link to either the practice patterns by the industry or the propensity to seek care by beneficiaries? Is it linked perhaps to higher rates of lack of secondary coverage, lower income, higher prices? I don't know. But there were two or three times, as I read the mail material, where I wondered whether or not the part of propensity to seek care and practice pattern that seems to be imbedded or account for a lot of that 38 percent, whether or not there is not a relationship between that and the 34 percent that we start with on the price side.

MS. BURKE: Can I just follow up to add to David's list of questions? To what extent are there also variances, and health status may pick this up, but in terms of the DI population? I mean, is that the entirety of where we represent that in terms of health status?

DR. ZABINSKI: I'm not sure, with the DI population?

MS. BURKE: The disabled.

DR. ZABINSKI: I was just thinking too hard what DI meant, so can you say that again?

MS. BURKE: My question is, is health status essentially a proxy for the difference that the disability population, those who are qualified for Medicare and participate in the program, is that the proxy for their utilization patterns and their propensity for services, which will be radically different than the basic Medicare population?

DR. ZABINSKI: Well, to the extent they're there, they're going to affect that measure because they're in the measure.

DR. NEWHOUSE: Another way to put that would be how much of the variation is accounted for by different proportions of the DI

population across counties.

MS. BURKE: Yes, because it has to have a dramatic impact on that question.

MR. SMITH: But shouldn't that be picked up, Joe, in county variations and health status?

DR. NEWHOUSE: Imperfectly. So it'll be what, given this multivariate approach, it'll be you could pick up some more of it that way I think, maybe not a lot, probably not a lot.

MS. ROSENBLATT: Particularly using the PIP-DCG, I don't think it would pick it up.

DR. ZABINSKI: But David's question on, just paraphrasing, I think he was saying is there some sort of correlation between the input prices and say the propensity to use care or --

MR. SMITH: To seek care.

DR. ZABINSKI: I would think there is. Joe might be able to answer that better than I can, but I would think there is.

DR. NEWHOUSE: My first reaction was that cost is low in the rural areas so that would promote utilization, but in fact we know utilization is lower there. Probably, you point to several reasons, Medigap being one, but also just distance. We know distance to provider affects use, even in urban areas, and there may well be health status differences there as well.

Can I continue or do you have somebody ahead of me on the list? I wanted to come back to Dave on the variation, and it kind of echoes Glenn, and it goes back to your earlier conversation about has M+C really hit bottom in the disenrollment.

The position of the Commission historically has been neutrality between M+C and traditional Medicare as the kind of desired principle, as Glenn said. So the issue that is joined then is, well, if we are going to try to do something about forcing or reducing variation in M+C rates and bringing St. Paul closer to Miami or however, we are going to unbalance local markets. In particular, that means if we give Miami 2 percent and the traditional program has markedly greater rate of cost increase, we are going to drive people back, in Miami, back toward the traditional program and out of M+C.

So, while I share your concerns about inappropriate use in the fee-for-service program and that probably varying across areas, it seems to me the effect of the policy of only working on variation in M+C is to, if anything, increase that.

MR. HACKBARTH: In fact, let me go back to your initial question about whether this belongs as an M+C issue or fee-for-service.

For the reason that Joe just articulated, I think we said several reports ago that this really needs to be a fee-for-service issue. If we're concerned about variation, it needs to be done with the dog and not the little tail that we call M+C.

I think it's timely because there is a lot of debate about the variation within the fee-for-service program, and at a minimum we could, as Joe said earlier, do some education about why the variation exists and perhaps even go so far as defraying the issues that would need to be addressed in trying to reduce that variation within the fee-for-service program.

Needless to say, it is a very difficult topic and a quite sensitive topic right now, but I think to put all of this in a M+C chapter is to put it in the wrong place.

DR. REISCHAUER: I agree with that completely.

Dan, I think this is terrific piece of work, even though it takes the thunder out of one section of speeches that I give.

[Laughter.]

MR. MULLER: You could use old data, Bob.

DR. REISCHAUER: Yes, I'll have to use old data and old analyses.

I just would be interested, not something that we'd ever publish, but to have this analysis done on an unweighted basis because that is where the political discussion is. People act as if Slope County, North Dakota, which is the lowest county in America, has as many people as Los Angeles County in it when they make these arguments and just to see how much of the variation is reduced. Now maybe you have done it.

DR. ZABINSKI: I've done that, and the difference --

DR. REISCHAUER: I'm setting you up.

DR. ZABINSKI: The difference, to me, is astounding. When you don't weight it, the effect of input prices is practically zero.

DR. REISCHAUER: It would be nice to have that table. You don't have to give it to everybody, just to me.

[Laughter.]

DR. ZABINSKI: Just a few thoughts on it.

DR. REISCHAUER: Mary was there, but too shy to speak, as always.

The other thing, and I'm not sure that this is appropriate for MedPAC, but it would be an interesting analysis, which is to take the residual variation that you have and run a regression to try and ferret out what it's related to, such as the fraction of the population with supplemental insurance, the availability of providers, hospital beds per capita or docs per capita, density or some other environmental factors, and of course the most important one, which would be health outcomes, you know, age-adjusted morality rate or something like that, and hope that that has a zero coefficient.

DR. ZABINSKI: One other thought on the input prices, just the underlying reason what's going on there, if you don't weight by the number of beneficiaries in the county, what happens is that most counties, nearly 90 percent of the counties in the United States have an input price that is below one. It is an index, so what you are doing essentially is spreading the distribution.

It sort of bothers me to do it that way, though, because the average of the input price should be one --

DR. REISCHAUER: The only reason you would want to do it is because it would allow you to understand how the political debate unfolds.

DR. ZABINSKI: Right.

DR. REISCHAUER: It shouldn't affect sort of the analysis.

DR. MILLER: I think this can be very short because I think I'm only going to say what I think I have heard here. I think

when we started out, the question was which direction we're going. So we're clearly on the fee-for-service side, and I feel like there is a couple of contributions that can be made here, and I think this drives off of comments mostly off of this end of the table. The notion of sort of clarifying -- and some down there, I guess -- clarifying the impact of the policy variable.

Some of how the policy variables play into the discussion, clarifying precisely when people are talking about input prices, trying to get the point across that input prices reflect general economy-wide prices and then to try and engage the discussion, and that people can end up in very different places just because of mixes of providers. If you have IME, GME, and DSH, and you don't have any teaching hospitals, that is going to affect where you end up. Try and illustrate that part of the debate more clearly.

And then the other side of the debate, which I think Glenn was speaking to, which is the extent it is not that, how do you deal with this complicated issue? And I don't think it's completely an issue of throwing up your hands and saying the program ends up setting standards, which I'm not sure what Glenn's point was anyway, but do you pay differentially either -- sorry.

MR. HACKBARTH: You could have asked me.

[Laughter.]

DR. MILLER: I know. I mean, can you pay differentially, I think we got the point over here, differentially as the program or differentially as the beneficiary for different kinds of services?

So I think, if I am trying to follow what the Commission is saying here and where we're going to go with our work, that's how I'm sort of organizing my thoughts for how we proceed from this point to try and drive at the analysis. Is that fair? I wanted to at least get that out.

MR. HACKBARTH: Okay. Thank you.